

August 31, 2026

Health Care Affordability and Mitigation Work Group
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners
1101 K Street, N.W., Suite 650
Washington, DC 20005

RE: AFFORDABILITY BRIEF EXPOSURE DRAFTS

Dear Health Care Affordability and Mitigation Work Group:

Thank you for the opportunity to comment on the Affordability Brief Exposure Drafts.

I am a Distinguished Senior Fellow in the Department of Health Services, Policy & Practice at the Brown University School of Public Health and a member of the Center for Advancing Health Policy through Research (CAHPR), an evidence-based, nonpartisan research and policy center that aims to make fundamental contributions toward understanding and developing policies that will lower spending growth, improve patient outcomes, and drive structural change in healthcare delivery in the U.S. I am also a consumer representative to the National Association of Insurance Commissioners.

Our center's work focuses on the design of insurance plans and their interactions within the health care market, employing a unique approach that integrates quantitative policy analysis with legal evaluation. This combined methodology helps identify the most effective legal and regulatory changes to create a significant impact.

This public comment, in response to the Affordability Brief Exposure Drafts, is informed by relevant research conducted by myself, Daniel Arnold, Hayden Rooke-Ley, Erin Fuse Brown, Roslyn Murray, Christopher Whaley, and Andrew Ryan, as well as other research from CAHPR and other organizations.¹

We support the Work Group's efforts to examine factors that contribute to rising health care costs and insurance premiums, and to identify state actions that address cost drivers. We offer two broad comments for the Work Group's consideration.

¹The opinions and conclusions expressed in this public comment are the author's alone and do not reflect those of Brown University, the Brown University School of Public Health or any of the research sponsors.

First, we recommend that the Work Group adopt a definition of affordability to guide its work. We recommend that this definition focus on lowering spending trends, with an emphasis on reducing costs for consumers as a whole. If the Work Group chooses not to adopt a definition of affordability, we encourage it to ensure each paper is transparent about how the policy initiatives affect affordability. For example, the papers should distinguish between a policy option that lowers spending trends and overall premiums and a policy option that offers a subset of (healthier) consumers access to lower-premium plans while increasing costs for other consumers, without addressing overarching spending trends. Adding transparency about how each policy initiative relates to affordability would improve the papers' utility and better enable policymakers to weigh the options presented.

Second, we encourage the Work Group to highlight where policy initiatives are supported by research; research regarding the cost drivers that the policy initiatives seek to target; and areas where research is lacking. Many of the policy initiatives described in the papers are new, as-yet-untested ideas. We understand why the Work Group has included these initiatives in the papers, but believe the papers would be more informative if they are clear on the state of research. To this end, in the remainder of this comment, we describe research, much of which was conducted by CAHPR researchers, that we recommend the Work Group consider as it revises the Affordability Briefs.

Drafting Group 1: Standardizing or Limiting Utilization Review to Reduce Administrative Costs

We encourage NAIC to consider perspectives from CAHPR's "Understanding Prior Authorization: Current Landscape, Practices, and Challenges" Issue Brief.² In that brief, we name risks that technological innovations (such as electronic prior authorization systems, automation processes, and artificial intelligence [AI]) may impose. Specifically, while these technologies can simplify workflows and reduce delays, they also risk new complexities or bias, lack of seamless integration, shifting administrative burden, and higher denial rates. We also note the lack of federal oversight over how health insurers develop and use algorithms, including AI, in prior authorizations and utilization management; the recent Interoperability and Prior Authorization final rule attempts to increase transparency in the use of AI but relies on industries to self-regulate their decision-making methods.

² Corrie Mook, Jeffrey Marr, Hayden Rooke-Ley, Jared Perkins, Lindsey Murtagh, Nathan Hostert, Ayesha Rahim. *Understanding Prior Authorization: Current Landscape, Practices, and Challenges*. February 2026. <https://doi.org/10.26300/psqz-1b42>

Drafting Group 2: Horizontal and Vertical Integration in Health Care

We encourage Drafting Group 2 to include in its paper a discussion of how horizontal and vertical integration has exacerbated affordability challenges, as understanding the mechanism behind this cost driver is important for understanding potential policy solutions. As health care markets become increasingly consolidated and uncompetitive, the health system becomes more fragile and the public is harmed by increased prices for health care items and services, reduced affordability, diminished wages, and hampered health care access, quality, and equity.³

We encourage the Drafting Group to review our white paper examining policy and legal options for addressing vertical integration in health care.⁴ In that paper, we argue that vertical integration of payers and providers can be a “mechanism for circumventing regulatory constraints and exploiting payment loopholes,” including: higher risk coding intensity by vertically-integrated organizations, site of service arbitrage in which hospitals and physician practices vertically integrate to gain access to additional facility fees and higher Medicare payment rates when the physical practice becomes hospital-affiliated, and Medical-Loss Ratio (MLR) gaming as insurers are able to shift profits across lines of business to circumvent MLR requirements.⁵ We go on to analyze the legal and policy options, including policy proposals not identified in this Affordability Brief, to address the risk of vertical integration. Such proposals relevant to states include:

- **Increasing ownership transparency** to allow for comprehensive identification of ownership relationships and related party payments among insurers, physician practices, pharmacies, and other health care entities. CAHPR’s Yashiswini Singh and Erin Fuse Brown argue that “lack of ownership transparency allows health care consolidation to intensify unchecked, with corresponding increases in prices.”⁶
- **Creating structural separation** to prevent insurers from buying medical practices or pharmacy benefit managers (PBMs) from owning pharmacies, eliminating the conflict of interest that occurs when the firm operates on both sides of a transaction. This policy “has a rich tradition in other highly regulated sectors.”⁷

³ Erin Fuse Brown, “Strengthening U.S. Economic Leadership: The Role of Competition in Enhancing Economic Resiliency,” testimony before United States Senate Judiciary Committee, Subcommittee on Competition Policy, Antitrust, and Consumer Rights, June 5, 2024, <https://doi.org/10.26300/3kz2-qw93>

⁴ Hayden Rooke-Ley, Anika Shah, Corrie Mook, and Erin Fuse Brown. *Health Care Conglomerates: Policy and Legal Options for Addressing Vertical Integration*. May 2026. <https://doi.org/10.26300/3ASF-MQ68>.

⁵ Rooke-Ley et al., *Health Care Conglomerates*.

⁶ Yashaswini Singh and Erin Fuse Brown. *The Missing Piece In Healthcare Transparency: Ownership Transparency*. September 2023.

<https://www.healthaffairs.org/content/forefront/missing-piece-health-care-transparency-ownership-transparency>

⁷ Singh and Fuse Brown, *The Missing Piece in Healthcare Transparency*.

- **Restricting corporate ownership** of medical practices and providers by modernizing state corporate practice of medicine (CPOM) prohibitions. CPOM statutes generally require that for-profit medical practices are owned by licensed clinicians delivering the care, but these existing regimes are “rife with loopholes” and are underenforced. In updating their CPOM laws, states could prohibit investor-backed management companies, including insurance companies, from being de facto owners of medical practices. States can also reevaluate ownership rules for other providers, such as hospitals, home health, hospice, and other providers experiencing vertical integration.⁸

We also refer the Drafting Group to research by CAHPR’s Dan Arnold⁹ describing one impact of vertical integration. Dan Arnold’s research finds that United Healthcare paid Optum practices (both of which are owned by UnitedHealth Group), relative to rival insurers, 17% more than non-Optum practices, which may enable UnitedHealth Care to “create an uneven playing field that makes it more difficult for independent practices to compete. This could lead to independent practices closing or joining larger groups such as Optum.”

Drafting Group 3: Develop State-defined Plans with Premium Reduction Targets

We appreciate that the Drafting Group highlighted CAHPR research regarding the impact of the Colorado Option plans on affordability. We take this opportunity to provide a more nuanced framing of our findings regarding the Colorado Option and to emphasize that these findings are preliminary. CAHPR researchers hope to conduct a more thorough analysis and welcome continued engagement with the Drafting Group. The draft brief describes our findings as follows: “the addition of Colorado Option plans to the individual market led to premium reductions of over \$100, even for non-Option plans.”¹⁰ In our analysis, however, we frame the findings as that “the Colorado Option was associated with a \$101 reduction in monthly premiums per enrollee for the lowest- and second-lowest cost silver plans relative to comparison states with reinsurance programs.”¹¹

⁸ Rooke-Ley et al., *Health Care Conglomerates*.

⁹ Daniel Arnold and Brent Fulton. *UnitedHealthcare Pays Optum Providers More Than Non-Optum Providers*. November 2025. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00155>

¹⁰ Sarah Bailey, Kate Harris, Maddie Davis, Lindsay Swartz, and Rachel Bowden. *NAIC Health Care Affordability and Mitigation Working Group: Reference Based Pricing*.

¹¹ Roslyn Murray and Christopher Whaley. *Estimating the Individual Market Premium Impacts of the Colorado Option*. January 2025. [https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Brief_%20Colorado%20Option%20Premiums%20\(1\).pdf](https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Brief_%20Colorado%20Option%20Premiums%20(1).pdf)

We also note additional nuance presented in the Mathematica study that is cited in the draft brief. This draft brief appropriately describes the finding that “the average Bronze premium paid between 2019 and 2022 by consumers who later enrolled in a Colorado Option was \$426, compared to \$452 among consumers who never enrolled in a Colorado Option.”¹² However, the Mathematica analysis goes on to provide important quantification that provides a fuller picture of the impact of the Colorado Option. The Mathematica researchers go on identify that the difference in average premiums paid by those in Colorado Option plans and non-Option plans grew between 2022 and 2025.¹³ The difference in premiums for Silver plans increased from \$2 in 2022 to \$48 in 2025.¹⁴ The Mathematica analysis found that “consumers who chose Colorado Option plans experienced a small but meaningful decrease in average monthly premiums relative to a comparison group who did not enroll in Colorado Option plans.”¹⁵

More generally, we also note that this affordability brief includes several significantly different policy initiatives, but the cited research relates to the policy initiatives regarding public options. We recommend revising the policy brief to clarify that the research on premium impacts and savings does not relate to mandate-lite plans, discuss evidence gaps around mandate-lite plans, and, absent research, discuss the pros and cons associated with mandate-lite plans.

Drafting Group 4: Reference-Based Pricing

We again take this opportunity to add nuance to our research findings cited in the draft brief. Our analysis of Rhode Island’s affordability standards found that these affordability standards were associated with a 9.1% reduction in hospital prices relative to comparison states across both fully insured and self-insured markets between 2012 and 2022. Commercial hospital prices in Rhode Island decreased from 106% of the national average in 2012 to 84% of the national average in 2022. We estimated that the affordability standards reduced aggregate premiums and out-of-pocket spending for the fully insured market by an average of \$87.7 million annually but increased expenditures by \$30.7 million annually. The standards were also associated with an average annual reduction in aggregate hospital commercial revenue of \$1583 million.¹⁶

Based on this research, we also identified key takeaways and considerations from Rhode Island’s implementation that we encourage the Drafting Group to incorporate into its Affordability Brief:

¹² Bailey et al., *Reference Based Pricing*

¹³ R. Vincent Pohl, Alli Steiner, Monica Lazaro Davadi, Kara Nester, Leah Faunce, Monica Farid, and Becca Gordon. *Analysis of the Colorado Option, pursuant to § 10-16-1310, C.R.S.* January 2026.
<https://doi.colorado.gov/sites/doi/files/documents/CO-Option-10-16-1304-Report.pdf>

¹⁴ Pohl et al., *Analysis of the Colorado Option*.

¹⁵ Pohl et al., *Analysis of the Colorado Option*.

¹⁶ Ryan et al., *Rhode Island’s Affordability Standards Led to Hospital Price Reductions and Lower Insurance Premiums*.

- Enforceable caps on hospital price growth created by the affordability standards meaningfully reduced hospital price growth, but other states attempting to implement similar tools vary in the mechanisms available for enforcement or rate regulation.
- The structure of state insurance markets and regulation may affect how savings are passed on to individuals as premium reductions. The Rhode Island Office of the Health Insurance Commissioner actively regulates rates and limits rate increases, which may explain observed premium reductions in the fully insured segment despite its highly concentrated dynamics.
- Although hospital growth caps may spill over into the self-insured segment and lead to lower prices, this may not result in reductions to self-insured premium equivalents.
- Because the standards were associated with a substantial reduction in hospital commercial revenue, the hospital price growth caps under the standards may need to be periodically recalibrated to avoid undue financial strain on hospitals.

Our most recent analysis of the Rhode Island affordability standards found that hospital acquisition of clinicians and physician practices increased more slowly in Rhode Island compared with other New England states after the affordability standards were in place and that professional fees for hospital-affiliated clinicians in the state decreased relative to clinicians in other New England states.¹⁷

We also refer the Drafting Group to additional research conducted by CAHPR researchers regarding hospital payment caps. One study evaluated the savings associated with Oregon's adoption of hospital caps for its state employee health plan.¹⁸ In this study, the authors estimated that implementing the caps was associated with \$107.5 million in savings to the state employee plan during the first two years. A separate analysis by CAHPR researchers estimated the potential savings that could be achieved by widespread adoption of hospital payment caps by state employee health plans, and the impact on commercial hospital operating margins.¹⁹

Lastly, we also take this opportunity to recommend revisions to more accurately describe federal policy:

¹⁷ Roslyn C. Murray, Christopher M. Whaley, and Andrew M. Ryan, "Rhode Island Affordability Standards and Hospital-Affiliated Clinician's Professional Fees," *JAMA Network Open* 9, no. 8 (2026) <http://doi.org/10.1001/jamanetworkopen.2026.30849>

¹⁸ Roslyn C. Murray, Zach Y. Brown, Sarah Miller, Edward C. Norton, and Andrew M. Ryan, "Hospital Facility Prices Declined as a Result of Oregon's Hospital Payment Cap," *Health Affairs* 43, no. 3 (2024): 424–32, <https://doi.org/10.1377/hlthaff.2023.01021>.

¹⁹ Roslyn C. Murray, Christopher M. Whaley, Erin C. Fuse Brown, and Andrew M. Ryan. *Hospital Payment Caps Could Save State Employee Health Plans Millions While Keeping Hospital Operating Margins Healthy*. December 2024. <https://doi.org/10.1377/hlthaff.2024.0069>

- On page 2, the draft brief states that “for out-of-network care governed by the No Surprises Act, in the absence of a state-regulated payment standard, plans must pay the qualifying payment amount (QPA).”²⁰ Although the QPA is used to calculate a consumer’s cost sharing and is relevant in the process for determining out-of-network payment amounts when a dispute is brought to the Federal Independent Dispute Resolution process, federal law does not require plans to pay the QPA for items or services subject to the No Surprises Act.²¹
- On page 3, we recommend noting, in the discussion of ERISA plans and state employee plans, that the FAQs issued by the Departments of Labor, Health and Human Services, and the Treasury offer guidance only on group health plan obligations under Public Health Service Act section 2707(b), and note that additional requirements apply to non-grandfathered plans in the individual and small group market that must provide coverage of essential health benefits.
- On page 3, we note that the CMS rule to allow non-network plans to be certified as qualified health plans, subject to state approval, is currently enjoined.

Drafting Group 6: Direct-to-Consumer Drug Platforms

In its discussion of direct-to-consumer platforms, this brief highlights both direct-to-consumer sales offered by pharmaceutical manufacturers and direct-to-consumer telehealth platforms. We encourage this committee to consider perspectives we raise in our analysis “Partnerships between Pharmaceutical and Telehealth Companies — Increasing Access or Driving Inappropriate Prescribing?”²² In that analysis, we examine legal risks associated with pharmaceutical manufacturers’ online platforms that direct users to websites run by telehealth companies that have clinicians available to prescribe medications after a virtual consultation. Namely, these concerns include:

- **Potential violations of the Anti-Kickback Statute**, which prohibits both pharmaceutical companies from compensating a telehealth company on the basis of the number or monetary value of prescribed products and a telehealth company from paying a pharmaceutical company for making patient referrals. While the Anti-Kickback Statute does not apply to private insurance, the considerations discussed may be relevant for states with state anti-kickback laws that apply to private insurance.

²⁰ Bailey et al., *Reference Based Pricing*

²¹ 86 Fed. Reg. 36,872, 36,901 (July 13, 2026), stating, “These interim final rules do not require plans and issuers, when making an initial payment to providers or facilities, to make any specific amount of minimum initial payment.”

²² Erin Fuse Brown, Olivier Wouters, and Ateev Mehrotra. *Partnerships between Pharmaceutical and Telehealth Companies – Increasing Access or Driving Inappropriate Prescribing?* March 2025.
<http://doi.org/10.1056/NEJMp2500379>.

- **Lack of reporting of financial arrangements** obfuscates potentially illegal or inappropriate relationships between pharmaceutical manufacturers and telehealth companies.
- **Quality-of-care implications**, as prescriptions under these arrangements may be financially motivated rather than based on clinical appropriateness. We do note that studies have not evaluated the care provided under these partnerships, and the evidence from other studies is mixed.^{23, 24}
- **Failure to disclose risks of a prescription**, as telehealth companies and their advertisements are not subject to the strict disclosure requirements of pharmaceutical advertisements.

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We appreciate the opportunity to offer comments on the Health Care Affordability and Mitigation Work Group's exposure drafts. In addition to the comments submitted here, we welcome continued involvement with the committee on these important issues. Should you have any questions or would like to discuss our comments or research further, please contact Lindsey Murtagh, Distinguished Senior Fellow, at Lindsey_Murtagh@brown.edu, or Nathan Hostert, Director for State Policy, at nathan_hostert@brown.edu.

Sincerely,



Lindsey Murtagh, JD, MPH

Distinguished Senior Fellow in the Department of Health Services, Policy & Practice
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²³ Kristin Ray, Zhuo Shi, Courtney Gidengil, Sabrina Poon, Lori Uscher-Pines, and Ateev Mehrotra. *Antibiotic Prescribing During Pediatric Direct-to-Consumer Telemedicine Visits*. May 2019. <http://doi.org/10.1542/peds.2018-2491>, finding that practitioners providing direct-to-consumer telehealth services prescribe antibiotics at higher rates than primary care clinicians seeing patients for in-person visits.

²⁴ Tara Jain, Eleanor Schwarz, and Ateev Mehrotra. *A Study of Telecontraception*. September 2019. <http://doi.org/10.1056/NEJMc1907545>, finding that clinicians working for telehealth vendors effectively screened for contraindications to oral contraceptives.